DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacies
All Prescribers
Managed Care Plans

Memorandum No: 04-23 MAA
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From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Prescription Drug Program: Prior Authorization Updates**

Effective for the week of June 1, 2004, and after, the Medical Assistance Administration (MAA) will implement the following changes to the Prescription Drug Program:

- Changes in drugs requiring Prior Authorization;
- Additions to the Expedited Prior Authorization (EPA) List; and
- Deletions from the Expedited Prior Authorization (EPA) List.

Changes in drugs requiring Prior Authorization

The following drugs will require prior authorization:

Drug
Synarel® (nafarelin acetate)
Nembutal® (pentobarbital sodium)

Additions to the Expedited Prior Authorization (EPA) List

Drug	Code	Criteria
Lamisil® (*terbinafine*)		Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions:
	042	a) Diabetic foot;
	043	b) History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	044	c) Pain from onychomycosis that results in significant functional impairment (e.g. difficulty wearing shoes or performing normal activities); or
	045	d) Fingernail involvement with or without chronic paronychia.

Drug	Code	Criteria
Sporanox® (*itraconazole*)		Must not be used for a client with cardiac dysfunction such as congestive heart failure.
	047	Use for patients with systemic fungal infections and dermatomycoses. Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions:
	042	a) Diabetic foot;
	043	b) History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	044	c) Pain from onychomycosis that results in significant functional impairment (e.g. difficulty wearing shoes or performing normal activities); or
	045	d) Fingernail involvement with or without chronic paronychia.
Symbyax® (*olanzapine/fluoxetine*)	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is 6 years of age or older.
Toprol XL® *(metoprolol XL)*	041	Diagnosis of congestive heart failure.

Deletions from the Expedited Prior Authorization (EPA) List

- **<u>MAA has removed the EPA requirement from the following drugs. These drugs will require prior authorization:</u>**

  Synarel® (nafarelin acetate)
  Nembutal® (pentobarbital sodium)

- **MAA has removed the EPA requirement from the following drugs. These drugs will be covered without prior authorization:**

Actonel® (risedronate sodium)
Advil® suspension (ibuprofen suspension)
amiodarone
Aredia® (pamidronate disodium)
Aricept® (donepezil)
Avonex® (interferon beta-1A)
Azelex® (azelaic acid)
Betapace® (sotalol)
Betaseron® (interferon beta-1B)
Calcimar® (calcitonin-salmon)
Children's Advil® (ibuprofen suspension)
clonazepam
Compazine® spansules (prochlorperazine maleate)
Copaxone® injection (glatiramer acetate)
Cordarone® (amiodarone)
cyanocobalamin injection (vitamin B-12 injection)
Danocrine® (danazol)
Differin® (adapalene)
Enemeez® (docusate sodium)
Evista® (raloxifene HCl)
Exelon® (rivastigmine tartrate)
Fosamax® (alendronate sodium)
ibuprofen suspension
INFeD® (iron dextran)
Klonopin® (clonazepam)
Miacalcin®, Miacalcin® Nasal Spray (calcitonin-salmon)
Motrin® suspension (ibuprofen suspension)
Pacerone® (amiodarone)
Rebif® (interferon beta-1A/albumin)
Reminyl® (galantamine hydrobromide)
Rilutek® (riluzole)
Rythmol® (propafenone)
Sandostatin® (octreotide acetate)
Seconal® (secobarbital sodium)
Tambocor® (flecainide acetate)
Therevac Plus® (docusate sodium/benzocaine)
Therevac SB® (docusate sodium)
Ticlid® (ticlopidine)
Tonocard® (tocainide)
vancomycin IV/Inj.
Venofer® (iron sucrose complex)
vitamin B-12 injection
Zenapax® (daclizumab)
Zovirax® ointment (acyclovir)

Attached is Section H of MAA's Prescription Drug Program Billing Instructions, dated February 2003, reflecting the above changes to the Expedited Prior Authorization list.

Drug	Code	Criteria
Abilify® *(Aripiprazole)*	015	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is **6** years of age or older.
Accutane® *(Isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent:** a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
Adderall® *(Amphetamine/ Dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; **and** b) Patient is **3** years of age or older.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.
Adderall XR® *(Amphetamine/ Dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Patient is **6** years of age or older; and c) Total daily dose is administered as a single dose.
Adeks® Multivitamins	102	For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all of the following: a) Patient is under medical supervision; and b) Patient is not taking oral anticoagulants; and c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

Drug	Code	Criteria
Aggrenox® *(Aspirin/ Dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Altace® *(Ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(Zolpidem tartrate)*	006	Short-term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Atacand® (Candesartan cilexetil)
Atacand HCT® (Candesartan cilexetil/HCTZ)
Avalide® (Irbesartan/HCTZ)
Avapro® (Irbesartan)
Benicar® (Olmesartan medoxomil)
Cozaar® (Losartan potassium)
Diovan® (Valsartan)
Diovan HCT® (Valsartan/HCTZ)
Hyzaar® (Losartan potassium/HCTZ)
Micardis® (Telmisartan)
Micardis HCT® (Telmisartan/HCTZ)
Teveten® (Eprosartan mesylate)
Teveten HCT® (Eprosartan mesylate/HCTZ)

Drug	Code	Criteria
Anzemet® *(Dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Avinza® *(Morphine sulfate)*	040	Diagnosis of cancer-related pain.
Bextra® *(Valdecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; c) Be 18 years of age or older; d) Have an absence of sulfa allergy; and e) Have an absence of history of rash while on Bextra.
	078	Diagnosis of osteoarthritis or rheumatoid arthritis and dose is limited to 10 mg per day.
	079	Diagnosis of primary dysmenorrhea and dose limited to 20mg two times per day.
Calcium w/vitamin D	126	Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.
Celebrex® *(Celecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; c) Be 18 years of age or older; and d) Have an absence of sulfa allergy.
	139	Diagnosis of osteoarthritis and dose is limited to 200mg or less per day.

Drug	Code	Criteria
	140	Diagnosis of rheumatoid arthritis and dose is limited to 400mg or less per day.
	145	Diagnosis of colorectal polyps and dose is limited to 400mg or less per day. (Exempt from trial with two generic NSAIDs.)
	147	Diagnosis of acute pain, including primary dysmenorrhea, and dose is limited to 600mg the first day and a maximum of 400 mg on subsequent days.
Clozapine **Clozaril®**	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is **17** years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(Methylphenidate)*	149	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber, and b) Patient is **6** years of age or older.
Dexedrine® *(D-Amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-Amphetamine sulfate)*		See criteria for Adderall®.

Drug	Code	Criteria
Duragesic® *(Fentanyl)*	040	Diagnosis of cancer-related pain.
Focalin® *(Dexmethylphenidate)*		See criteria for Concerta®.
Geodon® *(Ziprasidone)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is **6** years of age or older.
		***Note:** Because Geodon® prolongs the QT interval (> Seroquel® > Risperdal® > Zyprexa®) it is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Infergen® *(Interferon alfacon-1)*	134	Treatment of chronic hepatitis C viral (HCV) infection in patients **18** years of age or older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	033	Diagnosis of chronic hepatitis B in patients **1** year of age or older.

Drug	Code	Criteria
	107	Diagnosis of malignant melanoma in patients **18** years of age or older.
	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients **18** years of age or older.
Kadian® *(Morphine sulfate)*	040	Diagnosis of cancer-related pain.
Kytril® *(Granisetron)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with total body or abdominal radiotherapy.
Lamisil® (*Terbinafine*)		Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	044	Pain from onychomycosis that results in significant functional impairment (e.g. difficulty wearing shoes or performing normal activities); **or**
	045	Fingernail involvement with or without chronic paronychia.
Levorphanol	040	Diagnosis of cancer-related pain.
Marinol® *(Dronabinol)*	035	Diagnosis of cachexia associated with AIDS.
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD®		See criteria for Concerta®.
Miralax® *(Polyethylene glycol 3350)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Naltrexone		See criteria for ReVia®.
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(Ferrous Fumarate/ Folic acid)* **Nephro-Vite®** *(Vitamin B Comp W-C)* **Nephro-Vite RX®** *(Folic acid/Vitamin B Comp W-C)* **Nephro-Vite +FE®** *(Fe fumarate/FA/ Vitamin B Comp W-C)* **Nephron FA®** *(Fe fumerate/Doss/ FA/B Comp & C)*		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.
Ansaid® *(Flurbiprofen)* **Arthrotec®** *(Diclofenac/misoprostol)* **Clinoril®** *(Sulindac)* **Daypro®** *(Oxaprozin)* **Feldene®** *(Piroxicam)* Ibuprofen Indomethacin **Lodine®**, **Lodine XL®** *(Etodolac)* Meclofenamate **Mobic®** *(Meloxicam)* **Nalfon®** *(Fenoprofen)* **Naprosyn®** *(Naproxen)* **Orudis®**, **Oruvail®** *(Ketoprofen)*		

Drug	Code	Criteria
Ponstel® *(Mefenamic acid)* **Relafen®** *(Nabumetone)* **Tolectin®** *(Tolmetin)* **Toradol®** *(Ketorolac)* **Voltaren®** *(Diclofenac)*		
Oxandrin® *(Oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia b) Nephrosis c) Carcinoma of the breast d) Carcinoma of the prostate e) Pregnancy
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(Oxycodone HCl)*	040	Diagnosis of cancer-related pain.
PEG-Intron® *(Peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Pegasys® *(Peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients **18** years of age or older.

Drug	Code	Criteria
Plavix® *(Clopidogrel bisulfate)*	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once a day aspirin therapy.
Pravachol® *(Pravastatin)*	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Pulmozyme® *(Deoxyribonuclease)*	053	Diagnosis of cystic fibrosis and the patient is **5** years of age or older.
Rebetron® *(Ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Rena-Vite® **Rena-Vite RX®** *(Folic Acid/Vit B Comp W-C)*	096	Treatment of patients with renal disease.

Drug	Code	Criteria
ReVia® *(Naltrexone)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy. **Note:** A certification form must be on file with the pharmacy before the drug is dispensed. *(Sample copy of form attached.)*
Risperdal® *(Risperidone)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is **6** years of age or older.
Ritalin LA®		See criteria for Concerta®.
Roferon-A® *(Interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age or older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age or older.
Seroquel® *(Quetiapine fumarate)*	054	See criteria for Risperdal®.
Sonata® *(Zaleplon)*		See criteria for Ambien®.
Soriatane® *(Acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age or older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Sporanox® (I*traconazole*)	Must not be used for a client with cardiac dysfunction such as congestive heart failure.	
	047	Use for patients with systemic fungal infections and dermatomycoses. Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions: 042 Diabetic foot; 043 History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy; 044 Pain from onychomycosis that results in significant functional impairment (e.g. difficulty wearing shoes or performing normal activities); or

Drug	Code	Criteria
	045	Fingernail involvement with or without chronic paronychia.
Strattera® *(Atomoxetine HCl)*	007	All of the following must apply: a) Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD); and b) Patient is 6 years of age or older.
Suboxone® *(Buprenorphine/ Naloxone)*	019	Before this code is allowed, the patient must meet <u>all</u> of the following criteria. The patient: a) Is 16 years of age or older; b) Has a <u>DSM-IV-TR</u> diagnosis of opioid dependence ; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified chemical dependency treatment program.

Drug	Code	Criteria
		Limitations: • No more than a 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. <u>The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;</u> • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to six months of buprenorphine treatment for detoxification and stabilization. **<u>Note</u>:** A Buprenorphine-Suboxone Authorization Form [DSHS 13-720] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www.wa.gov/dshs/dshsforms/forms/eforms.html
Symbyax® (*Olanzapine/ fluoxetine*)	**048**	All of the following must apply: a) Diagnosis of depressive episodes associated bipolar disorder; and b) Patient is 6 years of age or older.
Talacen® *(Pentazocine/ acetaminophen)* **Talwin NX®** (*Pentazocine)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.

Drug	Code	Criteria
Toprol XL® *(Metoprolol XL)*	041	Diagnosis of congestive heart failure
Vancomycin®	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vioxx® *(Rofecoxib)*		Before any code is allowed, the patient must: a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; and c) Be 18 years of age or older.
	050	Diagnosis of rheumatoid arthritis and dose limited to 25mg or less per day.
	051	Diagnosis of osteoarthritis and dose limited to 12.5 to 25mg per day.
	052	Diagnosis of acute pain, including primary dysmenorrhea and dose is limited to 50mg or less per day for 5 days.
Vitamin ADC Drops	093	The child is breast-feeding, and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(Bupropion SR and XL)*	014	Treatment of depression.
Zofran® *(Odansetron)*		See criteria for Kytril®
Zometa® *(Zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® **Zyprexa Zydis®** *(Olanzapine)*	054	See criteria for Risperdal®.

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